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Nos. 96-110 & 95-1858

IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

STATE OF WASHINGTON, ET AL., *Petitioners*,

v.

HAROLD GLUCKSBERG, ET AL., *Respondents*.

&

DENNIS C. VACCO, ET AL., *Petitioners*,

v.

TIMOTHY E. QUILL, ET AL., *Respondents*.

On Writs of Certiorari to the United States Court of Appeals
for the Ninth & Second Circuits

BRIEF AMICI CURIAE OF GARY LEE, M.D., WILLIAM PETTY, M.D., FRITZ BECK, JUNE BECK, WILLOWS RESIDENTIAL CARE FACILITY, SISTER GERALDINE BERNARDS, MARYVILLE NURSING HOME, INC., JANICE ELSNER, CLAUDINE STOTLER, JEFFREY M. WEINKAUF, AND PHYSICIANS FOR COMPASSIONATE CARE IN SUPPORT OF PETITIONERS

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QUESTIONS DEALT WITH HEREIN

1. Whether safeguards will protect vulnerable persons from duress, undue influence, and the affects of depression if a constitutional right to assisted suicide is recognized.

2. Whether safeguards will be repeatedly challenged and frequently struck down.

3. Whether the recognition of a constitutional right to assisted suicide will be limited to persons who are competent, terminally ill, and otherwise making a voluntary decision.

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INTEREST OF AMICI CURIAE[1]

With one exception, the amici curiae are the plaintiffs who successfully challenged Oregon Ballot Measure 16 which legalized physician-assisted suicide in the state of Oregon. *Lee v. State of Oregon*, 891 F. Supp. 1421 (D.Or. 1995). That case is currently on appeal before the U.S. Court of Appeals for the 9th Circuit. A decision in this case recognizing a constitutional right to physician-assisted suicide would negatively impact their case on appeal. The *Lee* plaintiffs oppose any recognition of a constitutional right to assisted suicide because vulnerable persons cannot be adequately protected from undue influence, duress, and the affects of depression.

Gary Lee, M.D., is a physician licensed in the State of Oregon who is a resident of and practices medicine in Eugene, Oregon. All of his patients are cancer patients, many of whom will die with advanced cancer. Many of these patients suffer from depression; however, physicians are not well-trained in diagnosing depression so this problem is generally undertreated. Depression makes patients who have the disability of a terminal disease highly susceptible to undue influence in the form of suggestions that their lives are not worth living. He asserts the interests of his patients who have the disability of a terminal disease who do not wish to engage in assisted suicide but may be subject to internal and external pressures toward assisted suicide which they may be unable to resist given the lack of appropriate safeguards.

William Petty, M.D., is a physician licensed in the State of Oregon who is a resident of and practices medicine in Portland, Oregon. Eighty percent of his patients are cancer patients, and many will die as a result of their disease. He observes that these patients are especially susceptible to undue influence because they become vulnerable and compliant. He asserts the interests of his patients who have the disability of a terminal disease.

Janet Elsner is a person with progressive muscular dystrophy who uses a wheelchair. She is 46 years old and is a resident of Portland, Oregon. Ms. Elsner has had periods where she is so weak that she is limited to a liquid diet because she is too tired to

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[1]Consents from the parties to filing this brief have been filed with the Clerk.

eat. At such times, she cannot even turn over in bed. She does not know how long she has to live and has already lived longer than expected. She has problems with depression as a result of her illness and understands that depression may go undiagnosed and cause persons to consider suicide. She joins this brief on her own behalf and as a representative of those persons who have the disability of a terminal disease even with medical treatment.

Claudine Stotler is a resident of Washington County, Oregon, who has been diagnosed by her physician with cancer from which she will die. Ms. Stotler would never want to consider assisted suicide but understands that persons who have the disability of a terminal disease are sometimes subject to undiagnosed depression or undue influence while in a debilitated state and become persuaded to act contrary to their true intent, which she would never want to happen to her. She has been subject to depression at times since being diagnosed with cancer. She joins this brief on her own behalf and as a representative of those persons who have the disability of a terminal disease even with medical treatment.

Jeffrey M. Weinkauf is an insulin-dependent individual with diabetes, who is a resident of Eugene, Oregon. Oregon Ballot Measure 16 defines "terminal disease" as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months." Under this definition, Mr. Weinkauf's diabetes might constitute a terminal disease because it is an incurable and irreversible disease and, without insulin treatment, he will die within six months. The statute thus does not differentiate between diseases which are controllable with regular medication and those which are not. He joins this brief in his own behalf and as a representative of those persons who have a possibly terminal disease absent medical treatment.

Fritz and June Beck are residents of Bandon, Oregon, and are owners of The Willows Residential Care Facility, located in Bandon. Sister Geraldine Bernards is an Oregon resident and the Administrator of the Maryville Nursing Home, Inc., located in Beaverton, Oregon. These nursing homes house persons who have the disability of a terminal disease. If assisted suicide is legalized,

they would be required to permit the assisted suicide of a patient who has the disability of a terminal illness in their facility under Oregon Ballot Measure 16. Furthermore, they would be required to appoint a witness to witness any written consents to assisted suicide and would be prohibited from excluding physicians who wish to commit assisted suicide on their premises from prescribing lethal drugs to qualified residents of their facility. Because of their strong religious opposition to such practice, they believe they would have their free exercise of religion violated, contrary to the guarantees of the First Amendment and the Religious Freedom Restoration Act. In addition, they believe their First Amendment right to freedom of association would be violated if they were forced to allow assisted suicide to occur in their facility.

Physicians for Compassionate Care (PCC) is an Oregon nonprofit corporation with membership open to physicians, nurses, and other health care professionals. Its membership consists of over 500 health care professionals. Its purpose is to promote compassionate care for severely ill patients without sanctioning or assisting their suicide. Members affirm an ethic based on the principle that all human life is inherently valuable and that the physician's roles are to heal illness, alleviate suffering, and prolong life. Most of the organization's members treat patients who are terminally ill. It was not a plaintiff in the *Lee v. Oregon* case.

SUMMARY OF THE ARGUMENT

What this Court is being asked to do is to recognize a right to assisted suicide (by lethal dose of drugs) for competent people which will invalidate all state laws prohibiting assisted suicide. This brief will present three public policy reasons why such a constitutional right should not be recognized.

First, the decision of the 9th Circuit assumes that "sufficient safeguards can and will be developed by the state and medical profession." However, there are no safeguards that will be sufficient to protect vulnerable persons from duress, undue influence, and the affects of depression if a constitutional right to assisted suicide is recognized. This can be seen by an analysis of the safeguards in Oregon Ballot Measure 16, which became law in

November 1994, but was enjoined prior to its effective date by the U.S. District Court. At first blush, these safeguards seem reasonable enough and they are probably typical of the type of safeguards that will be proposed whenever assisted suicide is legalized. However, these safeguards are inadequate because they clearly fail to protect vulnerable persons. The record of the Oregon case, upon which the preliminary and final injunctions were issued, establishes certain key facts, which are summarized as follows: (1) physicians are unable to accurately diagnose a person as having a "terminal disease"; (2) people with terminal illness commonly suffer from the psychiatric illness of depression or other form of impaired judgment; (3) primary care physicians have difficulty in diagnosing depression; (4) depression is a major factor leading to suicide; (5) depression is treatable; (6) major life decisions should not be made while one is depressed; (7) recovery from depression takes more than 15 days; (8) patients with terminal illness are vulnerable to external pressures and abuse; and (9) drug overdoses are notoriously unreliable in actually causing death. For these reasons, the typical safeguards being proposed today are inadequate to protect the lives of vulnerable persons from undue influence, duress, and clinical depression.

Second, any proposed safeguards will undoubtedly be challenged and frequently struck down. This can be seen from the abortion litigation of the past twenty-five years. The 9th Circuit recognized this fact when it stated: "In deciding 'right-to-die' cases, we are guided by th[is] Court's approach to the abortion cases." Because abortion safeguards have been repeatedly challenged and frequently struck down in the past, we can expect the same result regarding any proposed assisted suicide safeguards. Therefore, if this court recognizes a new constitutional right to assisted suicide, the abortion precedents will control and will result in the striking down of many if not most safeguards. Physician-assisted suicide will be uncontrollable.

Third, the recognition of a constitutional right to assisted suicide will not be limited to persons who are terminally ill and mentally competent. The case law establishing a right to refuse life-sustaining medical treatment is binding precedent which will

permit assisted suicide for persons who are not terminally ill, and surrogate decisionmaking for persons who are incompetent, comatose, or in a persistent vegetative state. The 9th Circuit recognized this when it specifically included "the act of refusing or terminating unwanted medical treatment" within the liberty interest it was examining. Similarly, if a right to assisted suicide is recognized, equal protection clause jurisprudence will require the recognition of a right to euthanasia (by lethal injection) for those who cannot take a lethal dose by mouth, and a right to mercy killing for those who are incompetent, comatose, or in a persistent vegetative state or otherwise unable to exercise their constitutional rights without assistance. Physician-assisted suicide will necessarily result in the legalization of euthanasia and mercy killing.

For these public policy reasons this Court should hold that there is no right to assisted suicide in the Constitution of the United States, and should find that the decisions of the Second and Ninth Circuits should be reversed and/or vacated.

ARGUMENT

I. Safeguards Will Not Protect Vulnerable Persons.

In *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996), the 9th Circuit held that "a liberty interest exists in the choice of how and when one dies, and that the provision of the Washington statute banning assisted suicide, as applied to competent terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors, violates the Due Process Clause." *Id.* at 838. It also stated that "we believe that sufficient safeguards can and will be developed by the state and medical profession to ensure that the possibility of error will ordinarily be remote." *Id.* at 824. When the medical facts are analyzed, it is clear that the safeguards envisioned by the court will not be sufficient to protect vulnerable persons. The 9th Circuit cites the procedural safeguards in Oregon's Ballot Measure 16 as "a good example of how these legitimate and important concerns [i.e., errors, abuses, and legitimate state interests] can be addressed effectively." *Id.* at 833 & n.122.

The State of Oregon is the first state to legalize physician-

assisted suicide. However, before the law went into effect, it was successfully challenged by the *amici* herein, who are the plaintiffs in the case of *Lee v. Oregon*, 891 F. Supp. 1421 (D. Or. 1995). The U.S. District Court issued preliminary and permanent injunctions. *Id.* at 1439 (permanent injunction); 869 F. Supp. 1491 (D. Or. 1994) (preliminary injunction). It is now on appeal before the U.S. Court of Appeals for the 9th Circuit. A right to assisted suicide, whether created by referendum, by statute, or by recognition of a new constitutional right, constitutes an exception to the plethora of state laws protecting vulnerable persons. For example, the following Oregon statutes protect its vulnerable citizens.

Oregon Revised Statutes § 163.117 provides that:

> It is a defense to a charge of murder that the defendant's conduct consisted of causing or aiding, without the use of duress or deception, another person to commit suicide. Nothing contained in this section shall constitute a defense to a prosecution for, or preclude a conviction of, manslaughter or any other crime.

Oregon Revised Statutes § 163.125 provides that:

> (1) Criminal homicide constitutes manslaughter in the second degree when:
>
> (a) It is committed recklessly; or
>
> (b) A person intentionally causes or aids another person to commit suicide.
>
> (2) Manslaughter in the second degree is a Class B felony.

Oregon Revised Statutes § 161.205 provides that:

> The use of physical force upon another person that would otherwise constitute an offense is justifiable and not criminal under any of the following circumstances: . . . . (4) A person acting under a reasonable belief that another person is about to commit suicide or to inflict serious physical self-injury may use physical force upon that person to the extent that the person reasonably believes it necessary to thwart the result.

Oregon Revised Statutes § 426.005 defines a "mentally ill person" as, inter alia, "a person who, because of a mental disorder is . . . [d]angerous to self . . . ." Oregon Revised Statutes

§ 426.070 et seq. provide commitment proceedings for one who is a "mentally ill person," including emergency commitment proceedings.

While the foregoing statutes protect most Oregon residents from self-harm and assisted suicide, Oregon has by Ballot Measure 16 determined that the lives of persons who have the disability of a terminal disease, who are suffering from depression or undue influence, are not entitled to the same protections from self-harm and assisted suicide as those not deemed terminally ill.

The following are the relevant provisions of Ballot Measure 16: (1) a written request by an adult who has been determined by two physicians to be suffering from a terminal disease; (2) two witnesses who attest that the patient is capable, acting voluntarily, and not under coercion; (3) the attending physician shall inform the patient of his diagnosis, prognosis, potential risks in taking a lethal medication, the probable result, and the feasible alternatives; (4) the consulting physician shall examine the patient and his records, confirm in writing the diagnosis, verify that the patient is capable and acting voluntarily; (5) if either physician thinks the patient may be suffering from a psychiatric or psychological disorder, or depression, he will refer the patient for counseling; (6) the attending physician shall ask the patient to notify the next of kin of his request for medication; (7) a fifteen day waiting period; (8) civil and criminal immunities for the physicians and health care providers. At first blush, these safeguards seem reasonable enough and they are probably typical of the type of safeguards that will be proposed whenever assisted suicide is legalized.[2]

However, these safeguards are inadequate because they clearly fail to protect vulnerable persons. The record of the Oregon case, upon which the preliminary and final injunctions were issued, establishes certain key facts, which are summarized as follows: (1) physicians are unable to accurately diagnose a person as having a "terminal disease"; (2) people with terminal illness commonly

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[2]These are the type of "appropriate, reasonable, and properly drawn safeguards" suggested by the 9th Circuit. Compassion in Dying v. State of Washington, 79 F.3d 790, 833 (listing example safeguards that could be adopted).

suffer from the psychiatric illness of depression or other form of impaired judgment; (3) primary care physicians have difficulty in diagnosing depression; (4) depression is a major factor leading to suicide; (5) depression is treatable; (6) major life decisions should not be made while one is depressed; (7) recovery from depression takes more than 15 days; (8) patients with terminal illness are vulnerable to external pressures and abuse; and (9) drug overdoses are notoriously unreliable in actually causing death.

First, physicians are unable to accurately diagnose a person as having a "terminal disease." The U.S. District Court in Oregon found that "physicians often misdiagnose terminal illness" and that "a physician's prognosis of six months to live is often fallible." *Lee v. State of Oregon*, 869 F. Supp. 1491, 1497. The *Affidavit of Richard Fenigsen, M.D., Ph.D.*[3] gives evidence of a 20-40% error rate even in the clinical diagnosis of a particular disease. *Fenigsen Affidavit* at ¶ 6. The Oregon defendants did not contest this fact. In one study, lung cancer was misdiagnosed in over 49% of the cases. *Id.* A report in the *British Medical Journal* of four patients referred to a hospice for terminal care with "untreatable cancer" revealed that they had neither terminal illness nor cancer. *Id.* at ¶ 7. "One of these patients had the [erroneous] diagnosis of cancer established (from pleural biopsy) by two pathologists and confirmed by a third." *Id.* Defendants did not contest these facts. As to the ability of a physician to predict that a patient will die of a disease within a certain amount of time, even if correctly diagnosed, that ability is "notoriously fallible." *Id.* at ¶ 17. Oregon defendants' *Affidavit of Timothy M. Quill, M.D.* (C.R. 84) appends an article by Dr. Quill in which he writes, "we acknowledge the inexactness of such prognostications [about whether a patient is

[3]Appellees' Supplemental Excerpts of Record 111 (hereinafter Supp. E.R.), Clerk's Record 33 (hereinafter C.R.), Lee v. Harcleroad, Nos. 95-35804, 95-35805, 95-35854, 95-35948, 95-35949 (9th Cir. Jan. 24, 1996). Richard Fenigsen, M.D., Ph.D., has forty years of experience with severely ill and dying patients in the Netherlands. He has twenty years experience with euthanasia and physician-assisted suicide as practiced in hospitals and by family physicians in the Netherlands. His affidavit was cited by the Oregon District Court at 869 F. Supp. at 1497.

'near death']." *Id.* at Appendix D-2. According to the Michigan Supreme Court, "[n]o clear definition of 'terminal illness' is medically or legally possible, since only in hindsight is it known with certainty when someone is going to die." *People v. Kevorkian*, 447 Mich. 436, 467 n.34, 527 N.E.2d 714, 726 n. 33 (1994). Thus, the purported safeguard of a "medically confirmed diagnosis carries a risk of error ranging from 20 to 40 percent." *Fenigsen Affidavit* at ¶ 8. Clearly, many "qualified patients" under Measure 16 will not actually be within six months of dying as Measure 16 envisions.

Second, people with terminal illness commonly suffer from the psychiatric illness of depression or another form of impaired judgment. The *Affidavit of Carol J. Gill, Ph.D.*[4] establishes that

> [m]ost crisis intervention models allow a *minimum* of five weeks for resolution of the acute emotional disorder attending major personal loss. Crisis counselors recognize that the judgment of a person who is *legally* competent and grossly oriented to reality and logic may nonetheless be emotionally distorted when reacting to overwhelming loss.

Id. at ¶ 18 (emphasis in original). Receiving a diagnosis of a terminal disease is clearly a major life stress and personal loss. A pamphlet entitled *Depression: What You Need to Know*, published by the National Institute of Mental Health (no date), at 4, and placed in the *Lee v. Oregon* record as an attachment to the affidavit of Intervenor Levin (Exhibit 28 to Exhibits to Intervenor Levin's "Motions Against Plaintiffs' Claims"; C.R. 149), confirms Dr.

[4]Supp. E.R. 21, C.R. 29. Carol J. Gill, Ph.D., is a clinical psychologist specializing in issues affecting persons with disabilities, pain, and/or chronic illnesses. She has worked clinically with this population in both hospital settings and private practice. Her former positions include: Director of Rehabilitation Psychology at Glendale Adventist Medical Center, Commissioner in Psychology on the Los Angeles County Commission on Disability; and Acting Director of the Program in Disability and Society at the University of Southern California. For the past five years, she has devoted her professional life to research and education projects concerning persons with disabilities and chronic illness. She is currently the President of the Chicago Institute of Disability Research. Her affidavit was cited by the Oregon District Court at 869 F. Supp. at 1498 n.2.

Gill's assertion, stating that: "A serious loss, chronic illness, difficult relationship, financial problem, or any unwelcome change in life patterns can also trigger a depressive episode." Thus, many people with the major life stress of a diagnosis of terminal illness will suffer from depression, whether or not it rises to the level of clinical or major depression, and will have impaired judgment for making life and death decisions, even though legally competent. The New York State Task Force on Life and Law, in an exhaustive study entitled *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994),[5] noted that "[i]ndividuals with serious chronic and terminal illness face an increased risk of suicide—some studies suggest that the risk for cancer patients is about twice that of the general population." New York Task Force at 13. The New York Task Force summed up the link between terminal illness and depression as follows:

> Depression may coincide with other medical conditions for several reasons. First, the medical condition may biologically cause depression. Second, the condition may trigger depression in patients who are genetically predisposed to depression. Third, the presence of illness of disease can psychologically cause depression, as is often observed in patients with cancer. Finally, especially for cancer patients, some treatments or medications have side effects that cause depressive moods or symptoms.

New York Task Force at 15. However, the task force found that

> [i]t is a myth . . . that severe clinical depression is a normal and expected component of terminal illness. Healthy individuals, including health care professionals, often believe that it is normal for terminally ill patients to experience major depression. They understand feelings of hopelessness as expected and

[5]The task force was convened in 1985 by Governor Mario Cuomo, who charged the twenty-five-member body with developing recommendations for state public policy on a variety of issues. The report, hereinafter referred to as "New York Task Force," has been recognized as authoritative and relied upon by the Ninth Circuit Court of Appeals in the case of *Compassion in Dying v. State of Washington*, 49 F.3d 586 (9th Cir. 1995).

> rational given the patient's condition and prognosis.

New York Task Force at 16. Further, some will clearly be at risk for depression at the time when they take the lethal overdose, when Measure 16 provides no safeguards to screen out those who are acting incompetently.

Third, primary care physicians have difficulty in diagnosing depression. In the *Affidavit of Patricia Wesley, M.D.*,[6] Dr. Wesley, a psychiatrist and neurologist teaching in the Department of Psychiatry at Yale, cites a study by "David Clark, a major researcher in suicides, and others," of men 65 years and older who committed suicide. *Id.* at ¶ 26 (*citing* David C. Clark, *"Rational" Suicide and People with Terminal Conditions or Disabilities*, 8 Issues in Law & Med. 147, 152 (1992)). The study showed that

> 25% had been to a physician within 24 hours of death, 41% within one week of death, and 70% within one month of death. These contacts were for vague physical complaints. The general physician did not, and probably could not have, picked up either the psychiatric condition or the suicidal intention, at least as they were diagnosed retrospectively, by the psychological autopsy technique used in this study.

Id. Dr. Wesley concluded:

> The above data indicate that it is not an easy task to diagnose either psychiatric illness or suicidality, and that such tasks are probably beyond the expertise of most non-psychiatric physicians. Nonetheless, [Measure 16] asks just such busy, front-

[6]Supp. E.R. 11, C.R. 28. Patricia Wesley, M.D., is an assistant clinical professor of psychiatry in the Department of Psychiatry, School of Medicine, Yale University, New Haven, CT, where she supervises psychiatric residents in their outpatient psychotherapy work. Her other professional responsibilities include the evaluation and treatment of seriously and persistently mentally ill individuals in two outpatient facilities in New York City. One of these facilities exclusively serves individuals 55 and over, many of whom have significant medical problems. While she does not personally manage their medical conditions, she has gained considerable exposure to the impact of significant medical illness on psychological functioning. Her affidavit was quoted and cited by the Oregon District Court at 869 F. Supp. at 1498 n.2.

line, untrained physicians to perform this vital screening function. It will inevitably be done poorly, and many whose wish to die is based on psychiatric disturbance will be aided in killing themselves.

Id. at ¶ 27. Dr. David C. Clark concurs that psychiatric evaluation and treatment is necessary for terminally ill persons seeking suicide:

> The definitions of "attending physician" and "consulting physician" in the Act permit any licensed physician, regardless of experience or specialty training, to function in these roles. There is no requirement that either party have any knowledge or expertise in evaluating mental status, cognitive state and functioning, or psychiatric disorder beyond the fundamentals most physicians are exposed to in medical school. The medical/surgical literature is very clear and consistent in showing that medical/surgical general practitioners and specialists (other than psychiatrists) fail to recognize at least half of all cases of clear-cut major depressive illness in their own practices—i.e., among their own patients—and then they are not successful at recognizing the more severe half of cases. It is my professional opinion that the Act should include a requirement that trained and experienced mental health professionals examine each patient who makes a request for assisted suicide. This would protect people who, in the state of clinical depression, request assisted suicide without the opportunity for treatment.

Affidavit of David C. Clark, Ph.D.[7] at ¶ 27. The latest literature on suicidology confirms the above facts. In the September-October 1995 issue of *Psychomatics*, Harvard Medical School psychiatrists Block and Billings confirm that:

> [d]epression and organic mental disorders are commonly seen among patients who request assistance in dying. These disorders can both impair patient autonomy and coexist with autonomous wishes for hastened death. Because of the irrevocability of hastening death, decisions about competency must be especially rigorous. Determination of competence in this setting is often extraordinarily challenging, requiring subtle evaluations of thought processes and complex assessments of the patient's cognitive understanding, affective and emotional appreciation, and character limitations in understanding the implications of alternative choices. Very rarely are nonpsychiatric clinicians adequately prepared to address this broad concept of competence, so psychiatric input is essential.

Susan M. Block, M.D. & J. Andrew Billings, M.D., *Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness: The Role of the Psychiatrist*, 5 Psychosomatics 445, 452 (1995). In the August 1995 issue of the *American Journal of Psychiatry*, a team of seven psychiatrists and other researchers reported the results of a Canadian study on the desire for death in the terminally ill—that terminally ill persons who desire death do so because of depression—and urged psychiatric involvement in such cases. Harvey M. Chochinov, M.D., Keith G. Wilson, Ph.D., Murray Enns, M.D., Neil Mowchun, M.D., Sheila Lander, R.N., Martin Levitt, M.D. & Jennifer J. Clinch, M.A., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185, 1190 (1995).

The Oregon record clearly shows on empirical evidence that there *is* "reason to believe" that primary care physicians, who are concededly not specially trained to diagnose and treat depression, are not capable at discovering, diagnosing, and treating depression. Finally, this fact is confirmed by the New York Task Force:[8]

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[7]Supp. E.R. 89, C.R. 32. David C. Clark, Ph.D., is Professor of Psychiatry, Psychology, and Preventive Medicine, and Director of the Center for Suicide Research and Prevention, at the Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois. His supplemental affidavit was cited by the Oregon District Court at 869 F. Supp. at 1501 n.4.

[8]The New York Task Force may be viewed as an impartial voice because it included both persons who favored and opposed assisted suicide personally, but all agreed that, even with attempted safeguards, there is too great a "risk of harm" in implementing a regime of state-endorsed assisted suicide, a risk which "is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized group." New York Task Force at 119.

> Even psychologists and psychiatrist who routinely treat and diagnose depression may have limited experience doing so for patients who are terminally or chronically ill. For those patients, clinicians must be able to distinguish realistic sadness and sense of loss that accompanies such illness from severe clinical depression or the psychiatric disorders that impair decision-making capacity. These disorders are prevalent in those patients who ultimately choose to commit or attempt suicide.

New York Task Force at 127-28.[9]

Fourth, depression[10] is a major factor leading to suicide. "Suicide is the eighth leading cause of death in the United States" and "is a major health problem." *Affidavit of David C. Clark, M.D. (Supp. E.R. 89; C.R. 32; at ¶ 3).* "Those aged sixty-five and over make up 12% of the population but account for 21% of all suicides." *Id.* Major suicide researcher Dr. David Clark reports:

> There is considerable agreement among the findings from the large community-based psychological autopsy studies on the relationship between major mental disorder and death by suicide. Never less than 88% of the subjects qualified for a psychiatric diagnosis at the time of the suicide (never less than 94% in all but one study). . . . Thus suicides rarely occur in

[9]Even where depression is diagnosed, it is often undertreated, New York Task Force at 127, leaving terminally ill persons at risk for suicide both because depression is undiagnosed and because it is undertreated.

[10]The term "depression" is used here and elsewhere herein as a shorthand expression for a range of judgment impairing psychopathologies. Because space and readability do not permit continued reference to a string of psychiatric diagnoses that may lead to suicide, necessity dictates that a shorthand substitute be used. The *Affidavit of David C. Clark, Ph.D.* (Supp. E.R. 89; C.R. 32) sets forth the wide range of psychopathologies which lead to suicide, including depression. Other treatable causes of suicidal ideation and attempt include unrelieved pain and suffering, substance abuse, organic problems, and side effects of certain treatments. While these latter are not psychiatric problems, they represent treatable conditions which can lead to suicidal impulses and should be recalled when the shorthand term "depression" is used herein.

> the absence of major psycho-pathology.

Id. at ¶ 4. Further, "15% of persons with major depression die by suicide." *Id.* at ¶ 6. A Canadian study on the desire for death in the terminally ill, reported in the August 1985 issue of the *American Journal of Psychiatry*, confirms the connection: "in the logistic regression analysis, depression emerged as the only predictor for the desire for death." Harvey M. Chochinov, M.D., Keith G. Wilson, Ph.D., Murray Enns, M.D., Neil Mowchun, M.D., Sheila Lander, R.N., Martin Levitt, M.D. & Jennifer J. Clinch, M.A., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185, 1190 (1995). The authors of the article cautioned that: "our findings indicate that a substantial proportion of terminally ill patients who express a desire to die could potentially benefit from a trial of treatment for depression." *Id.* A 1986 study, reported in the *American Journal of Psychiatry* questioned, on the basis of empirical evidence, "[t]he role of terminal illness, physical decline, or chronic pain as a reason for suicide." *Affidavit of David C. Clark, M.D.* (Supp. E.R. 89; C.R. 32) at ¶ 19. Dr. Clark reports of the study that

> Brown and colleagues, in a study of hospice patients diagnosed with terminal illness, severe pain, disfigurement, or disability, found that the great majority of these patients did not desire to die by suicide. Of the small percentage who expressed any wish to die, all met diagnostic criteria for major depressive illness.

Id. at ¶ 20.[11] From this and other evidence, Dr. Clark concluded:

> While it is compelling to assume that many persons with chronic, painful, or terminal illnesses will choose to end their suffering prematurely by opting for suicide, in fact this type of choice, usually referred to as "rational" suicide, is rarely seen in hospital and hospice work. Except in those cases where physical illness is accompanied by a major depressive illness,

[11]Such empirical evidence belies the notion that it is normal and rational for persons with a terminal illness to be depressed and want to kill themselves. *See also Affidavit of David C. Clark, M.D.* (Supp. E.R. 89; C.R. 32) at ¶¶ 9-12, 19-21, 23-25.

> the great majority of patients spontaneously reject the suicide option and choose to die naturally. The majority of terminally ill patients cling to life throughout their illnesses. Among older person, for whom chronic painful illnesses are not uncommon, only 0.5% of male deaths and 0.2% of female deaths are attributable to suicide.

Id. at ¶ 19. Clark concludes that

> [t]o wish to end life by killing oneself is almost always a serious symptom arising from a temporary psychiatric illness, even when the person is terminally ill. While the subtlety and complexity of depressive illnesses often make it difficult for loved ones to recognize the gravity of the problem, it is generally a mistake to assume that a wish to die or end one's own life is a rational, carefully thought-through decision justified by a person's life situation or health status. One should always suspect that an unrecognized psychiatric illness has silently, invisibly influenced the judgment of a patient opting for suicide. When a patient asks to die, the burden of proof should lie with those who wish to defend as "rational" a decision to die by suicide.

Id. at ¶ 31. The Oregon defendants' *Affidavit of Jerome A. Motto, M.D.* (C.R. 87) provides corroborating evidence of the link between depression and suicide, conceding that, by this criteria, half of all persons committing suicide "suffer from a psychiatric disorder" and that "one-third of all suicides suffer from clinical depression." *Id.* at ¶ 5.[12] Finally, the New York Task Force documented that "As explained by one sociologist who studied suicide: 'It is undeniable that all persons—100 percent—who commit suicide are perturbed and experiencing unbearable psychological pain.'" New York Task Force at 95 n.65 (quoting Edwin S. Schneidman, *Rational Suicide and Psychiatric Disorders*,

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[12]Other treatable reasons people seek suicide include unrelieved pain and suffering, New York Task Force at 128; substance abuse, *Affidavit of David C. Clark, M.D.* (Supp. E.R. 89, 91 ¶ 4; C.R. 32); psychological suffering, New Task Force at 94-95; and psychological pressure, *Affidavit of Gary E. Lee, M.D.* (Supp. E.R. 159, 162 ¶ 9; C.R. 36).

326 New Eng. J. Med. 889 (1992)).

Fifth, depression is treatable. "[D]epressed patients generally respond well to standard treatments for depressive illness—psychotherapy and some antidepressant medication." *Affidavit of David C. Clark, M.D.* (Supp. E.R. 89; C.R. 32) at ¶ 21. "In response to treatment, patients with terminal illnesses and intractable pain are usually grateful that no one facilitated their suicide while they were temporarily depressed or having acute difficulties with pain." *Id.* Oregon defendants' *Affidavit of Jerome A. Motto, M.D.* (C.R. 87) declares that Major Depressive Disorder, the "type of mood disorder that is often associated with suicidal states," "can usually be treated effectively with antidepressant medication." *Id.* at ¶ 4.

Sixth, major life decisions should not be made while one is depressed. As already noted, the *Affidavit of Carol J. Gill, Ph. D.* (Supp. E.R. 21; C.R. 29) establishes that

> [m]ost crisis intervention models allow a *minimum* of five weeks for resolution of the acute emotional disorder attending major personal loss. Crisis counselors recognize that the judgment of a person who is *legally* competent and grossly oriented to reality and logic may nonetheless be emotionally distorted when reacting to overwhelming loss.

Id. at ¶ 18 (emphasis in original). Dr. Gill continues: "[c]lients in crisis therapy are, therefore, cautioned not to make any major life decisions within five weeks of a critical life stress. The Act needlessly narrows this window to fifteen days." *Id.* The assertion that important decisions should not be made while one is depressed is uncontested.

Seventh, treatment for depression takes more than 15 days. As noted in the material quoted in the previous paragraph, resolution of acute emotional disorders takes a minimum of five weeks for resolution. This is uncontested. If treated depression will not resolve itself in less than five weeks, then 15 days is clearly too short a time for depression to resolve itself if undetected and untreated.

Eighth, patients with terminal illness are vulnerable to external

pressures and abuse. "[D]emoralizations and a lack of assertiveness may render the depressed terminally ill patient more vulnerable to the suggestions of others, thereby increasing the potential for abuse." Harvey M. Chochinov, M.D., Keith G. Wilson, Ph.D., Murray Enns, M.D., Neil Mowchun, M.D., Sheila Lander, R.N., Martin Levitt, M.D. & Jennifer J. Clinch, M.A., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185, 1190 (1995). *See also Affidavit of William Petty, M.D.*[13]

Ninth, drug overdoses are notoriously unreliable in actually causing death. Dr. Jerome R. Wernow, a pharmacist, has submitted evidence that 25% of assisted suicides will fail, based on the writings of Derek Humphrey, a Measure 16 proponent and a co-founder of the Hemlock Society (which advocates legalization of physician-assisted suicide and euthanasia). *Affidavit of Jerome R. Wernow, Ph.D.*[14] Dr. Wernow also cites evidence that barbiturate poisoning is the "most uncertain way of taking one's life," *id.* at ¶ 8, raising the specter of patient coma, renal damage, toxic psychosis, serious central nervous system damage, and protracted suffering for the patient and her family. *Id.* at ¶¶ 9-10.

From all these medical facts, Dr. Patricia Wesley, a psychiatrist teaching at the Department of Psychiatry at Yale, has concluded that

> [a]s David Clark puts it, "when a patient asks to die, the burden of proof should be with those who wish to defend a wish to die by suicide as a rational decision." Oregon's Death with Dignity Act has it precisely the other way round, and regards a terminally ill person's suicidal wishes as deserving of speedy implementation, unless proven otherwise. This law flies in the face of what we know about suicide and the

[13]Supp. E.R. 1, C.R. 23, at ¶ 10. William Petty, M.D., is one of the Plaintiffs in Lee v. Harcleroad (Oregon), and is a physician with offices in Portland, Oregon. Eighty percent of his patients are cancer patients.

[14]Supp. E.R. 169, C.R. 169, at ¶ 7. Jerome R. Wernow, Ph.D., is a pharmacist and biomedical ethicist in Oregon. His affidavit was cited by the Oregon District Court at 869 F. Supp. at 1502 n.5.

terminally ill.

Affidavit of Patricia Wesley, M.D. (Supp. E.R. 11; C.R. 28) at ¶ 30. As discussed *infra* this reversal of presumptions from those established by the facts of modern suicidology is irrational and based on erroneous, unscientific stereotypes about why people commit suicide.

The safeguards in Oregon Measure 16 are typical of the type of safeguards being proposed to protect against abuse. However, as can be seen from the above evidence and argument, those safeguards will be inadequate to protect the lives of vulnerable persons from undue influence, duress, and clinical depression.

II. If a Constitutional Right to Assisted Suicide is Recognized, Any Proposed Safeguards Will Undoubtedly Be Challenged and Frequently Struck Down.

The abortion litigation precedents of the past twenty-five years will control any new constitutional right to assisted suicide. The 9th Circuit declared:

> In deciding right-to-die cases, we are guided by the Court's approach to the abortion cases. Casey in particular provides a powerful precedent, for in that case the Court had the opportunity to evaluate its past decisions and to determine whether to adhere to its original judgment. Although Casey was influenced by the doctrine of stare decisis, the fundamental message of that case lies in its statements regarding the type of issue that confronts us here: "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment."

79 F.3d 801, 813-14 (citing *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 851). Thus, the right to die is founded upon and defined by abortion jurisprudence and precedents. If assisted suicide receives constitutional recognition, it is destined to become a super protected right like abortion.

The super protected right of abortion is illustrated by the fact that abortion safeguards have been repeatedly challenged and

frequently struck down. The following are a few examples of the abortion safeguards which have been challenged and defeated. It is clearly foreseeable that assisted suicide safeguards will also be challenged and defeated.

First, the 1986 case of *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986), demonstrates the problem states have in predicting and conforming to this Court's constitutional boundaries in forth in *Roe*.[15] As Justice O'Connor wrote in her dissent to *Akron*, the "bright lines" have become "blurred."[16] The challenged provisions of the Pennsylvania law in *Thornburgh* included an informed consent provision. It required physicians to make available state-prepared information concerning alternatives to abortion, available assistance for alternatives, and objective information regarding fetal characteristics and the possibility of fetal survival.[17] The physician was required to disclose (1) the possibility of unforeseeable psychological and physical risks of abortion,[18] (2) the availability of medical assistance benefits for prenatal care, childbirth, and neonatal care,[19] (3) the liability of the father for child support,[20] and (4) the probable gestational age of the fetus.[21] The court of appeals invalidated all of these provisions on the basis of this Court's decision in *Akron*.[22] We may expect that similarly detailed

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[15]Roe v. Wade, 410 U.S. 113 (1973).

[16]Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 455 (1983) (O'Connor, J., dissenting).

[17]18 Pa. Cons. Stat. § 3205(a)(2)(iii) (1983).

[18]*Id.* § 3205(a)(1)(ii).

[19]*Id.* § 3205(a)(2)(i).

[20]*Id.* § 3205(a)(2)(ii).

[21]*Id.* § 3205(a)(1)(iv).

[22]*Thornburgh*, 737 F.2d at 295-96. *See Akron*, 462 U.S. at 444-45. *But see*

informed consent requirements for assisted suicide will also be struck down.

Pennsylvania also included a parental consent provision which essentially codified the Supreme Court's holding in *Bellotti v. Baird*.[23] The appeals court enjoined enforcement of this until the Pennsylvania Supreme Court promulgated implementing regulations.[24] We expect that minors will also be recognized to have a right to assisted suicide and that parental consent requirements will be closely scrutinized so as to prevent any unconstitutional burden on the minor's exercise of his or her constitutional right to assisted suicide.

The Pennsylvania Act also required physicians to provide reports with a variety of data for statistical purposes.[25] Included was a report of the basis for the physician's determination that the fetus was not viable or "that the abortion [was] necessary to preserve maternal life or health."[26] The court of appeals invalidated these requirements because they were too extensive and complicated and, hence, were likely to increase the cost of an abortion and possibly have a chilling effect on physicians' willingness to perform abortions.[27] Reporting requirements for assisted suicide will likewise be considered unnecessary and burdensome.

Another Pennsylvania provision required health insurers to

Brief for the United States, *supra* note 17, at 7-8.

[23]18 Pa. Cons. Stat. § 3206 (1983). *See* Bellotti v. Baird, 443 U.S. 622, 648-51 (1979) (*Bellotti (II)*).

[24]*Thornburgh*, 737 F.2d at 297. *But see* Brief for the United States, *supra* note 17, at 4-5.

[25]18 Pa. Cons. Stat. § 3214 (1983) (requiring information included the physician's name, location of facility, woman's age, race and marital status, type of abortion procedure, and any complications).

[26]*Id.* § 3211.

[27]*Thornburgh*, 737 F.2d at 301-02. *But see* Brief for the United States, *supra* note 17, at 9-10.

make available policies that excluded elective abortion coverage (except in the case of rape or incest). These policies would have been mandatorily priced less than policies with abortion coverage.[28] The appeals court invalidated this as an unjustified barrier to a woman's access to abortion.[29] We can be sure that insurance policies will also provide coverage for physician-assisted suicide (clearly a way to reduce the cost of care at the end of life) and we will all pay for it through our insurance premiums.

This Court's holding in *Thornburgh* had major substantive rulings regarding informed consent, reporting requirements, and regulations designed to preserve the lives of viable, aborted fetuses. It invalidated almost every regulation Pennsylvania had passed.

Second, in 1990, this Court decided the case of *Hodgson v. Minnesota*, 497 U.S. 417 (1990). This action was brought challenging the parental notification requirement of the Minnesota Abortion Law. In an eight part majority opinion with four opinions concurring in part and dissenting in part. Of three issues that reached this Court, one provision of the statute was struck down as unconstitutional, and two provisions were upheld. The issues concerned the abortion statute's 48-hour waiting period between notification of parents of minor's intent to obtain abortion and performance of that abortion, and the requirement that both parents be notified of a minor's intent to obtain an abortion.

And third, this Court, in 1992, decided the case of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). Certain abortion clinics and a physician challenged the constitutionality of the 1988 and 1989 amendments to Pennsylvania's abortion statute. The United States District Court for the Eastern District of Pennsylvania held that several sections of the statute were unconstitutional. 744 F. Supp. 1323. The Court of Appeals for the Third District affirmed in part and reversed in

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[28]18 Pa. Cons. Stat. § 3215(e) (1983).

[29]*Thornburgh*, 737 F.2d at 303. *But see* Harris v. McRae, 448 U.S. 297, 316-17 (1980); Maher v. Roe, 432 U.S. 464, 474 (1977).

part. This Court affirmed in part, reversed in part, and held that: (1) the doctrine of stare decisis requires reaffirmance of *Roe v. Wade's* essential holding recognizing a woman's right to choose an abortion before fetal viability; (2) the undue burden test, rather than the trimester framework, should be used in evaluating abortion restrictions before viability; (3) the medical emergency definition in the Pennsylvania statute was sufficiently broad that it did not impose an undue burden; (4) the informed consent requirements, the 24-hour waiting period, parental consent provision, and the reporting and record-keeping requirements of the Pennsylvania statute did not impose an undue burden; and (5) the spousal notification provision imposed an undue burden and was invalid. Four concurring and dissenting opinions were filed. This undue burden test will no doubt be precedent for any constitutional right to assisted suicide.

These three decisions illustrate the complexity of abortion litigation and the fact that abortion safeguards have been repeatedly challenged and frequently struck down. If this Court recognizes a new constitutional right to assisted suicide, these cases will be precedent establishing physician-assisted suicide as a similar super protected right. The 9th Circuit already did so in its decision citing *Roe*, *Thornburgh*, *Webster*, and *Casey* in "defining [a] liberty interest [ ] identical to the approach used by the Supreme Court in the abortion cases." 79 F.3d at 801-03. It also declared, "In deciding right-to-die cases, we are guided by the Court's approach to the abortion cases. Casey in particular provides a powerful precedent." *Id.* "[T]he full scope of the liberty guaranteed by the Due Process Clause is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints." *Id.* at 803 (citing *Casey*, 505 U.S. at 848).

III. The Recognition of a Constitutional Right to Assisted Suicide Will Not Be Limited to Persons Who Are Terminally Ill and Mentally Competent.

The case law establishing a right to refuse life-sustaining medical treatment is binding precedent which will permit assisted

suicide for persons who are not terminally ill, and surrogate decisionmaking for persons who are incompetent, comatose, or in a persistent vegetative state. The 9th Circuit specifically included "the act of refusing or terminating unwanted medical treatment" within the liberty interest it was examining. 79 F.3d at 802. The act of refusing or terminating medical treatment is "subject to a balancing test that is less restrictive [than the compelling but narrowly tailored state interest], but nonetheless requires the state to overcome a substantial hurdle in justifying any significant impairment." *Id.* at 804. Further, the 9th Circuit based its decision squarely on *Cruzan*. *Id.* at 814-16.

However, if a right to assisted suicide is recognized, the right will not be limited to persons who are terminally ill and mentally competent. The 9th Circuit recognized this when it stated: "Our conclusion is strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults. We are influenced as well by the plight of others, such as those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness." *Id.* at 816.

Although the 9th Circuit did not reach the equal protection issue (*id.* at 838), the 2d Circuit did. Based on *Cruzan* and other refusal/termination of medical treatment cases, it held that those persons not receiving life-sustaining treatment also have a right to hasten death, by physician-assisted suicide. *Quill v. Vacco*, 80 F.3d 716, 729 (2nd Cir. 1996). Thus, equal protection clause jurisprudence will no doubt require the recognition of a right to euthanasia (e.g. lethal injection) for those who cannot take a lethal dose by mouth, and a right to mercy killing for those who are incompetent, comatose, or in a persistent vegetative state or otherwise unable to exercise their constitutional rights to consent. Physician-assisted suicide will necessarily result in the legalization of euthanasia and mercy killing.

The jurisprudence of cases asserting a right to refuse medical treatment will provide the precedent. The right to refuse medical treatment has roots in both the common law right to be free from invasion of one's bodily integrity, and the notion of battery, which is a rejection of unwanted touching. *Schloendorff v. Society of New*

York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914). However, beginning in 1976 with *In re Quinlan* 70 N.J. 10, 335 A.2d 647, *cert. denied sub nom.* Garzer v. New Jersey, 429 U.S. 922 (1976) (when the New Jersey Supreme Court authorized the removal of a ventilator from Karen Ann Quinlan, who was in a coma), many courts have expanded this right by holding that the U.S. Constitution, through the right of privacy, guarantees to individuals a fundamental right to reject medical treatment, including medical treatment without which they will die. Some courts have explicitly characterized this as a "right to die." The following are several cases illustrating the breadth of the right to die since *Quinlan*. These are the precedents which will control any recognized right to determine the time and manner of death.

First, there are cases where competent persons who were terminally ill requested the right to refuse life support: *Tune v. Walter Reed Army Medical Hospital*, No. 85-0697 (D.D.C. Mar. 4, 1985) (held that competent adult patients with terminal illnesses have a right to determine for themselves whether or not they wish their lives to be prolonged by artificial life support systems).

Second, there are cases where competent persons who were disabled but not terminally ill and requested the right to refuse life-sustaining treatment or tube feeding: *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (held that no compelling state interest in the preservation of human life exists that would outweigh a competent but disabled person's right to terminate treatment because "the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration." 225 Cal. Rptr. at 304);[30] *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) (ratified the right to die for competent persons with disabilities who were dependent on life-sustaining treatment in order to live, e.g. those it described as having "an artificially extended life," "artificial survival," and an unchanging interest in hastening "natural death" for lives "irreparably

[30]Ms. Bouvia has quadriplegia due to cerebral palsy. She has not chosen to exercise her hard won right to die.

devastated by injury or illness.");[31] and *State v. McAfee*, 259 Ga. 579, 385 S.E.2d 651 (Ga. 1989) (upheld a lower court decision permitting Larry McAfee to shut off the ventilator that he had used since his accident. The trial judge had ruled that McAfee's right to refuse life-sustaining treatment outweighed the state's interest in preserving life and stated: "The ventilator to which he is attached is not prolonging his life; it is prolonging his death.").[32]

Third, there are cases where the persons are incompetent, but have previously expressed their wishes regarding the use of life-sustaining treatment: *Brophy v. New England Sinai Hospital, Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986) (held that casual remarks made by a patient prior to the onset of any illness could be sufficient evidence to find that the now incompetent patient would, if competent, decline to receive nutrition and hydration by tube);[33] *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990) (upheld the state of Missouri's requirement that there be clear and convincing evidence that Nancy Cruzan previously decided to terminate her tube feeding in such circumstances as then existed, but did not require the clear and convincing standard be applicable in all states where removal of life-sustaining treatment and

[31]Kenneth Bergstedt was a thirty-one year old man with quadriplegia who died before the court's decision when his father, his primary caretaker, loosened the ventilator from his trachea after first administering Seconal and Valium. One week later, his father died from lung cancer. *Ailing Father Dies; Quadriplegic Had Ended Own Life for Fear Dad Would Go First*, San Diego Union, Oct. 12, 12,1990, at A27.

[32]*In re* McAfee, No. D-70960 (Super. Ct. Fulton County, Ga. Sept, 7, 1989). At the time, Larry McAfee was a thirty-four year old man with quadriplegia, after a sudden accident that left him disabled and on a ventilator. After joining the United Cerebral Palsy of Greater Birmingham, Georgia, he was trained in voice-activated computers and was employed in computerized design and drafting. He has not exercised his right to die. Applebome, *An Angry Man Fights to Die, Then Tests Life*, N.Y. Times, Feb. 7, 1990, at 1.

[33]Paul Brophy was forty-eight years old, unconscious or noncommunicative due to an aneurysm, but not terminally ill.

nutrition/hydration for incompetent patient was requested);[34] and *In re Browning*, 568 So.2d 4 (Fla. 1990) (authorized surrogates to withdraw life-sustaining treatment and tube feeding, without judicial approval, for incompetent patients who had previously expressed their wishes orally or in writing).[35]

Fourth, there are cases where termination of life-sustaining treatment was approved for persons who were incompetent and never previously expressed their wishes regarding the use of life-sustaining treatment: *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (held that provision of tube feeding constitutes medical treatment that can be withheld from persons who are comatose upon the request of the family);[36] *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985) (held that a feeding tube could be removed at the request of a guardian based upon the patient's constitutional right of privacy and common law right to informed refusal of medical treatment);[37] *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987) (held that a surrogate decisionmaker may withhold feeding by tube even when the incompetent patient has not left clear and convincing evidence of her intent);[38] and *In re Smerdon*, slip op. No. A-6031-89T1 (N.J. Super. Ct. App. Div. 1991) (held that a substitute judgment test should be applied when there is no clear and convincing evidence that the incompetent

[34]Nancy Cruzan was thirty-four years old, unconscious or noncommunicative due to an auto accident, but not terminally ill.

[35]Estelle Browning was ninety years old, incompetent due to a stroke, but conscious and communicative. She suffered from an incurable but not necessarily terminal illness. Her living will stated that tube feeding could be withheld or withdrawn if she was terminally ill and death was imminent.

[36]Clarence Herbert, the subject of this lawsuit, was fifty-five years old, comatose, but not terminally ill.

[37]Claire Conroy was eighty-three years old, incompetent but not comatose or in an unconscious state, and not terminally ill.

[38]Nancy Jobes was thirty-one years old, unconscious or noncommunicative due to an accident in surgery, but not terminally ill.

patient, while competent, wished to decline any medical treatment, including tube feeding).[39]

Fifth, there are cases where termination of life-sustaining treatment was approved for persons who had never been competent: *In re Sue Ann Lawrance*, 579 N.E.2d 32 (Ind. 1991) (held that the Indiana Health Care Act permits families to decide, in consultation with a physician, to withdraw life-sustaining treatment, including tube feeding, from never-competent patients in persistent vegetative state, without court approval, where there is unanimity among those with tangible personal or professional interest in the patient).[40]

And finally, there are cases where termination of life-sustaining treatment was approved for persons who were minors: *In re Swan*, 569 A.2d 1202 (Me. 1990) (held that pre-accident declarations made by a minor later left in a persistent vegetative state due to an accident may be found sufficient to satisfy a determination that clear and convincing evidence exists of the minor's decision to discontinue life-sustaining treatment and feeding tubes).[41]

Thus, based on the above decisions, the withdrawal of life-sustaining treatment includes withdrawal of life-sustaining treatment and tube feeding not only for those who are competent, terminally ill, and voluntarily electing to end their lives, but also persons who are comatose, in a persistent vegetative state, or otherwise incompetent, even those who were never competent including minors, whether they expressed their wishes prior to incompetency or not. Terminal illness is not required, only significant disabilities, or pain and suffering. For those who are

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[39]Theodore Smerdon was thirty-nine years old, unconscious and noncommunicative due to a stroke, but responded to pain, touch and smell, and was not terminally ill.

[40]Sue Ann Lawrance was forty-two years old, had never been competent due to mental retardation, was unconscious or noncommunicative due to a fall in 1987, but not terminally ill.

[41]Chad Swan was seventeen years old, unconscious or noncommunicative due to an automobile accident, but not terminally ill.

deemed competent, no psychological examination is required to determine if they are suffering from depression or other psychological disturbance. For those who are deemed incompetent, no clear and convincing evidence of their prior expressed wishes is required, only a surrogate's decision based on substituted judgment. In some states, no prior investigation, hearing, or approval by a court or other state official is required, only the unanimous agreement of family and physicians.

What was universally prohibited under traditional laws only a couple of decades ago, has now become commonplace, without significant safeguards for the patient, whether competent or not. Having achieved this level of casual disregard for human life, especially for those most vulnerable, we are now poised to leap from withdrawal of treatment and tube feeding in order to cause death, to the prescription of lethal doses, and under the equal protection doctrine as established in various precedents, the administration of lethal injections by syringe or intravenous line for those unable to take lethal doses by mouth.

If this Court opens the door of intentional killing by lethal dosing, there will be no effective safeguards for persons who are incompetent, especially persons who are mentally disabled with significant physical disabilities. The precedents cited above make it clear that any new constitutional right of assisted suicide will extend to persons who are not terminally ill, persons who are merely disabled and/or suffering physically, and persons who are comatose, in a persistent vegetative state, or otherwise incompetent.[42]

The question before this Court, although rather narrow in its present construction, is likely to impact the vast majority of the American people. Indeed, it will affect decisionmaking for everyone except those who are lucky enough to die quickly while in relatively good health and still living independently.

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[42]Yale Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide—And Why These Are Not Convincing*, 12 Issues in Law & Med. 113, 129 (1996).

For these reasons it is clear that the recognition of a constitutional right to assisted suicide will not be limited to persons who are competent, terminally ill, and otherwise making a voluntary decision.

CONCLUSION

For the above reasons, your *amici* respectfully pray this Court (1) to hold that there is no right to assisted suicide in the Constitution of the United States, and (2) to reverse and/or vacate the decisions of the United States Courts of Appeals for the Second and Ninth Circuits.

Respectfully submitted,

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AMICUS CURIAE

BRIEF

(26) (33)

Nos. 96-110, 96-1858

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

STATE OF WASHINGTON, *et al.*,
Petitioners,
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On Writs of Certiorari to the United States Courts of Appeals for the Ninth and Second Circuits

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BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

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BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

INTEREST OF THE *AMICUS CURIAE*

Amicus curiae, the American Hospital Association ("AHA"), respectfully submits this brief in support of Petitioners in *State of Washington v. Glucksberg*, No. 96-110, and *Vacco v. Quill*, No. 96-1858.[1]

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[1] The AHA has the written consent of Petitioners and Respondents in both cases to the filing of this brief. Letters indicating their consent have been filed with the Clerk of the Court.

Founded in 1898, the AHA is the primary organization of hospitals in the United States. The AHA's mission is to advance the health of individuals and communities. AHA leads, represents, and serves health care provider organizations that are accountable to the community and committed to health improvement. Its membership includes 70% of the Nation's 5,000 hospitals, health systems, and other providers of care. Over 38,000 health care professionals hold individual memberships in the AHA.

The AHA has played a significant role in the ongoing debate concerning end-of-life decisions. It has worked vigorously through the legislative and judicial processes to help secure the right of patients, in consultation with their families and their physicians, to forego life-sustaining medical treatment.[2] And it regularly publishes policies and ethical guidelines addressing the roles of patients, families, guardians, physicians, and hospitals involved in termination-of-care decisions.

The AHA and its members have a vital interest in the outcome of *Glucksberg* and *Quill*. If a constitutional right to physician-assisted suicide is recognized, AHA members will be called upon to assist in the suicide of patients on a daily basis in hospitals across the country. In the view of the AHA, recognition of such a right would create an administrative nightmare for hospitals and other health-care providers as courts struggle to define the parameters of this new right. For this and other reasons described below, the AHA joins virtually every medical association and governmental panel to study the issue in opposing the creation of a constitutional right to physician-assisted suicide.

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[2] *See, e.g.*, Brief of the AHA as *Amicus Curiae*, in Support of Petitioners in *Cruzan v. Director of Missouri Dep't of Health*, No. 88-1503 (S. Ct. Sept. 1, 1989) (urging recognition of right to refuse medical treatment).

SUMMARY OF ARGUMENT

The American Hospital Association supports the right of every patient to choose whether or not to accept medical treatment. This right includes the right to forego even life-sustaining medical treatment, including artificially delivered food and water. Patients, in consultation with their families and their physicians, should be able to make such determinations free from government interference. The right of a patient to accept or reject medical treatment is in keeping with a doctor's well-recognized obligation not to force treatment on an unwilling patient. It is also consistent with this Court's precedents and with the deeply-rooted traditions of this country.

A right to physician-assisted suicide, by contrast, finds no basis in the text or structure of the Constitution or in this Court's precedents. Nor is such a right so "deeply rooted in this Nation's history and tradition," *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977), that it may be deemed "fundamental" or "implicit in the concept of ordered liberty," *Palko v. Connecticut*, 302 U.S. 319, 325 (1937). To the contrary, physician-assisted suicide has long been illegal and continues to be so in the vast majority of states.

The American Hospital Association does not endorse state statutes criminalizing physician-assisted suicide. But the AHA cannot accept the assertion that the Constitution precludes such statutes. Under our system of government, democratically-elected officials should be able to grapple with this difficult issue free from "a background of federal constitutional imperatives that are unknown because they are being newly crafted from Term to Term." *Cruzan v. Missouri*, 497 U.S. 261, 293 (1990) (Scalia, J., concurring). Hospitals, medical associations, individual physicians, and their patients and communities should all be able to take part in shaping public policy on this issue based on ethical, medical, and political considerations. The Constitution does not preempt such informed dialogue.

Accordingly, the AHA believes that the Ninth Circuit decision being reviewed by this Court is both wrong and profoundly damaging to our constitutional scheme. The AHA also believes that the Second Circuit erred in failing to recognize a rational distinction between assisted suicide and the right to refuse medical care, which the AHA has long-championed.

ARGUMENT

I. THERE IS NO CONSTITUTIONALLY-PROTECTED LIBERTY INTEREST IN PHYSICIAN-ASSISTED SUICIDE

A. A Constitutionally-Protected Liberty Interest in Physician-Assisted Suicide Has No Basis in the Text or Structure of the Constitution or in This Court's Precedents

This Court has been understandably reluctant in recent years to expand the range of substantive due process rights protected by, though not mentioned in, the Constitution.

> The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional laws having little or no cognizable roots in the language or design of the Constitution. That this is so was painfully demonstrated by the face-off between the Executive and the Court in the 1930's, which resulted in the repudiation of much of the substantive gloss that the Court had placed on the Due Process Clauses of the Fifth and Fourteenth Amendments. There should be, therefore, great resistance to expand the substantive reach of those Clauses, particularly if it requires redefining the category of rights deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority.

Bowers v. Hardwick, 478 U.S. 186, 194-95 (1986).

The Ninth Circuit does not suggest that there is any basis in the language or design of the Constitution for a right to physician-assisted suicide. Rather, the court of appeals attempts to base its decision on two prior decisions of this Court, neither of which will bear that weight. *See Compassion in Dying v. State of Washington*, 79 F.3d 790, 812-16 (9th Cir. 1996) (relying on *Cruzan* and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992)).

In *Cruzan*, 497 U.S. at 278, the Court correctly recognized that its prior decisions supported "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment." At common law, every individual had a right to "bodily integrity," to be free of any physical intrusion without consent. Any unconsented to touching was a battery. Out of this right to be free of battery grew the doctrine of "informed consent" and its "logical corollary," which is that "the patient generally possesses the right not to consent, that is, to refuse treatment." *Id.* at 269-70. The right to refuse treatment was universally recognized in state law cases and in a series of Due Process Clause decisions leading up to *Cruzan*. *Id.* at 269-78.

In *Cruzan*, the Court assumed without deciding that "under the general holding of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest." *Id.* at 279. In other words, the Court assumed that the long-recognized right to refuse medical treatment includes the right to refuse even treatment necessary to sustain life. The Ninth Circuit has taken that assumption, which was well-grounded in the Court's precedents, and run with it into a wholly "uncharted area" where the "guideposts for responsible decisionmaking . . . are scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992).